Attachment 1- Additional Questions for the Record

Submitted to Ms. Kay Daly and Ms. Joyce Greenleaf

Department of Health and Human Services (HHS), Office of Inspector General (OIG)

Hearing entitled "Failure to Verify: Concerns Regarding PPACA's Eligibility System"

July 16, 2014

The Honorable Joseph R. Pitts

1. **I have heard reports from multiple groups representing employers that they have not been notified a single time by CMS, as required by the law, that an employee has received an advanceable premium tax credit. CMS should be verifying up front whether the employee has access to affordable coverage. This information is important since certain coverage offered by an employer would make individuals ineligible for tax credits. I am deeply disturbed at this account since many workers may be inaccurately receiving thousands of dollars in inaccurate tax credits and subsidies. Is OIG aware of a process in place to accurately and timely verify whether an applicant has an offer of affordable employer-sponsored coverage?**

   Section 1411(e)(4)(B)(iii) of the Affordable Care Act (ACA) requires that when an individual is determined eligible for a premium tax credit because such individual's employer does not provide affordable minimum essential coverage through an employer-sponsored plan, the marketplace must notify the employer of such fact and that the employer may be liable for a payment assessed under the Employer Shared Responsibility Provisions of the Internal Revenue Code. The Employer Shared Responsibility Provisions (also called the "employer mandate") require larger employers (generally, those who employ 50 full-time employees) to offer affordable health coverage that provides a minimum level of coverage to their full-time employees. If one of those employees receives a premium tax credit for purchasing individual coverage on the marketplace, the employer is subject to a shared responsibility payment. IRC § 4980H (added by ACA § 1513). CMS and IRS each implemented regulations to effectuate the employer mandate, which was to be effective for months beginning after December 30, 2013. 77 FR 18310 (Mar. 27, 2012); 78 FR 218 (Jan. 2, 2013). However, the effective date for the employer mandate was delayed by IRS to 2015 for employers with 100 or more full-time employees and to 2016 for employers with 50 to 99 full-time employees.[1] 79 FR 8544, 8569-8574 (Feb. 12, 2014). This delay, called "transition relief," was in response to employers' implementation concerns and was intended to provide employers

[1] More specifically, large employers (100 or more full-time employees) must cover 70% of their full-time employees by 2015; all employers with 50 or more full-time employees must cover 95% of full-time employees by 2016.

additional time to provide input and adapt their health coverage and reporting systems. (Notice 2013-45, IRS, available at http://www.irs.gov/pub/irs-drop/n-13-45.pdf.) Thus, it is our understanding that because enforcement of the employer mandate was delayed until at least 2015, the marketplaces were not notifying employers during the first open enrollment period.

The "transition relief" did not change eligibility requirements for applicants. To be eligible for premium tax credits, individuals must not be eligible for minimum essential coverage, including employer-sponsored insurance. An individual who is employed may still be eligible for tax credits and costs sharing reductions if the employer does not provide minimum essential coverage, provides coverage that is not affordable, or does not provide coverage that meets minimum value standards. CMS has indicated that legislative and operational barriers prevented HHS from requiring employers to report directly to the marketplace (78 Fed. Reg. 42160, 42255 (July 15, 2013)). Due in part to these barriers, HHS has implemented an interim process in regulation which allows the marketplace to accept an individual's self-attestation to verify that the individual does not have qualifying employer-sponsored coverage. However, , the marketplace must select a random sample of applicants whose self-attestation was not reasonably compatible with other data sources and contact their employers to verify whether the individual is enrolled in an employer-sponsored plan (45 CFR § 155.320(d)(3)(iii)).

Our reports covered the first open enrollment period and did not address employer notification. Our work examined inconsistencies between the applicant's information and information available through Federal and other data sources. CMS reported that 12 percent of inconsistencies from October 1, 2013 to February 24, 2014 concerned employer-sponsored minimum essential coverage, and that the Federal marketplace was unable to resolve these inconsistencies at that time. At the time of our report in June, the Federal marketplace had in place a manual process to resolve inconsistencies regarding several eligibility requirements, including employer-sponsored minimum essential coverage. CMS reported to OIG that throughout the summer, the agency has been developing an automated process to address inconsistencies in employer-sponsored coverage eligibility and other requirements.

2. **Has CMS informed OIG of any work plan with specific mile markers to work through the estimated 2.2 million applicants who have inconsistencies in their eligibility? In OIG's opinion, to protect the integrity of the program and safeguard taxpayer dollars, is it important for CMS to remove ineligible individuals before they are automatically re-enrolled in the second enrollment period?**

No, OIG has not yet received from CMS any work plan to address the 2.9 million inconsistencies we identified in our reports. We are continuing to follow up with CMS

regarding its plan for and status of inconsistency resolution. We note that the 2.9 million inconsistencies do not necessarily equate to 2.9 million applicants – one applicant may have multiple inconsistencies. At the time of our analysis, CMS was unable to determine the unique number of applicants with inconsistencies.

OIG agrees that ineligible individuals should not be enrolled, or re-enrolled in the program. (We note that an individual with an inconsistency is not necessarily ineligible so resolving inconsistencies is important to accurately determine initial or continued eligibility.) In early July, CMS proposed rules that would permit, in specified circumstances, automatic continuation of an individual in his/her current Qualified Health Plan (QHP) and, if applicable, continuation of premium tax credits and cost sharing reductions. (79 Fed. Reg. 37262 (July 1, 2014)). However, for this proposed process, all annual re-enrollments of qualified individuals must also include a redetermination of eligibility, which requires the marketplaces to check updated information to ensure that an individual remains qualified to enroll in his/her QHP and to receive a premium tax credit and/or cost-sharing reduction. 45 CFR § 155.335). There are only limited circumstances that would prohibit a marketplace from performing a full eligibility redetermination for an individual re-enrolling in a QHP (45 CFR § 155.335(l) & (m)).

3. What is OIG's estimate of the total possible estimate of subsidies inappropriately provided to individuals not eligible?

OIG does not have an estimate of the amount of financial assistance payments inappropriately provided to ineligible individuals. Our work examined the effectiveness of internal controls over marketplace eligibility and the marketplaces' ability to resolve inconsistencies between applicant information and other data sources. Neither of these reviews provides a basis for estimating inappropriate financial assistance amounts. Instead, our work provides important information about the key systems and processes in place to ensure accurate eligibility determination. Deficiencies in certain internal controls and unresolved inconsistencies may raise the risk of inaccurate determinations and financial assistance payments, but at this time, we cannot quantify that risk.

4. Is HHS OIG aware of whether or not CMS has procured a contract to build the backend system that has not yet been built? If so, please detail the scope of the contract and the contractor.

In January 2014, CMS selected Accenture Federal Services to replace CGI Federal as the lead contractor on the Federal marketplace. As such, Accenture Federal Services is responsible for monitoring and managing existing Federal marketplace applications as well as designing, developing, and implementing additional functionality, including

certain "backend systems" that facilitate enhanced financial management capabilities, eligibility verification and determination, and the Federally Facilitated Small Business Health Options Program (SHOP). As of June 5, 2014, CMS had obligated $175 million for the Accenture Federal Services contract.

5. **Given the ineligibilities OIG has identified in the FFM's enrollment process, does OIG have confidence that the individuals who the FFM determined are eligible for Medicaid are indeed eligible for Medicaid?**

   Our recently published reports focused on marketplaces and did not examine Medicaid eligibility. OIG has additional work under development that examines Medicaid eligibility. We would be happy to follow up with your office when we have results from our new work.

6. **How are states and/or the FFM determining whether or not childless adults enrolled in Medicaid are eligible for the full match (newly-eligible) or regular match (newly-enrolled/woodwork)?**

   OIG's completed work focused on the eligibility for Qualified Health Plans through the Federal and State marketplaces and did not examine Medicaid eligibility or the accuracy of Federal Medicaid Assistance Percentages (FMAP, or matching rates). OIG has additional work under development that examines Medicaid eligibility and FMAP. We would be happy to follow up with your office when we have results from that new work.

7. **Based on the work of OIG in documenting the problems with enrollment this past fall, in OIG's opinion, is CMS at this point adequately prepared to build, test and operate the backend system for the second open enrollment period?**

   In response to OIG's work regarding problems resolving inconsistencies related to enrollment for the first open enrollment period, CMS reported in May 2014 that it is using an interim manual system to reconcile inconsistencies and that it planned to replace the interim manual process for clearing the inconsistencies categories with the automated functionality later this summer.

   Speaking more broadly about CMS preparedness for the second open enrollment period, OIG is currently conducting work examining CMS' management of the Federal marketplace, which will include a case study of the period from passage of ACA through at least November of 2014, as well as CMS' oversight and management of contractors. Our analysis of documentation and interview data is not complete, but CMS has reported changes to its management of the Federal marketplace following the launch. These

changes include closer oversight by CMS leadership, a systems integrator, cross-functional teams, and a new contractor for the primary Federal marketplace build and maintenance. The interviews and documentation also show that work is not complete for all planned components. Should it encounter difficulty in completing the remaining work or in conducting testing, CMS may not be fully prepared for the second open enrollment period and could face functionality problems. OIG will continue to assess CMS management of the Federal marketplace and plans to assess the operation of second enrollment period systems at the appropriate time.

The Honorable Michael C. Burgess

1. **In the run up to the passage of the law, the President repeatedly assured the American people that illegal immigrants would not receive coverage under the ACA. Yet, your report states that nearly half of the 2.9 million inconsistencies were related to immigration status, meaning that there is a high likelihood that illegal immigrants are receiving tax payer funds for the purchase of health insurance. The law requires that inconsistencies in citizenship status be resolved within 90 days of notifying the applicant that their status cannot be verified. There is no exception.**

   Have the Administration and that State-based exchanges complied with this aspect of the law? In what ways are they in violation?

   Our reports addressed the marketplaces' ability to resolve inconsistencies. Examining how the marketplaces dealt with applicants who were unable to resolve inconsistencies with citizenship and immigration status was outside of the scope of our reports and the report periods. For this reason, we do not currently have information about actual terminations of coverage or withdrawal of financial assistance.

   As a general matter, when an inconsistency in citizenship or immigration status occurs, the marketplace must first make a reasonable effort to identify and address the causes of this inconsistency by contacting the applicant to confirm the accuracy of the information on the application. If the marketplace is unable to resolve this inconsistency through reasonable efforts, the marketplace provides the applicant 90 days from the date on which the notice is received by the applicant to present satisfactory documentation to resolve the inconsistency. Generally, the date on which the notice is received means 5 days after the date on the notice. According to regulations, a marketplace may extend the inconsistency period, including inconsistencies regarding citizenship and immigration status, if an applicant demonstrates that a good-faith effort has been made to submit satisfactory documentation to resolve the inconsistency. 45 C.F.R. § 155.315(c)(3), (f)(3).

On August 12, 2014, CMS announced that the Federal marketplace had begun to send notices to consumers with an immigration status or citizenship inconsistencies who have not responded to previous notices. CMS announced that those consumers must act now to submit supporting documents by September 5 or their marketplace coverage will end on September 30.

2. **In December, I sent a letter to HHS inquiring about a number of back-end issues, particularly the so-called IRS APTC reconciliation process. HHS never responded to my inquiries. It seems that the reconciliation process is more of a theory and less of a process. Can you provide any details about this reconciliation process with the IRS? Has the system to implement this process been developed?**

   IRS is responsible for the development and implementation of the APTC reconciliation process to verify whether income information submitted by applicants, when applying for a premium tax credit, matches the income information provided during the tax filing process. We are coordinating with the Treasury Inspector General for Tax Administration (TIGTA) to examine the reconciliation process, including the effectiveness of IRS procedures for recouping unauthorized payments or overpayments of premium tax credits. We would be happy to brief you about our portion of this work.

3. **The report says that during your investigation, IRS did not grant you access to Federal taxpayer information that IRS provides to marketplaces. Do you have a timeline for when you will be able to access this information?**

   We are working closely with the IRS to gain access to Federal Tax Information (FTI) at both the Federal and State marketplaces. Such access is governed by provisions of the Internal Revenue Code. Currently, IRS has concluded that the Internal Revenue Code (as amended by ACA) does authorize OIG access to FTI for the Federal marketplace. OIG staff members who will access this data for our work have recently completed training on the appropriate protocols and safeguards necessary to safely and securely access, use, and protect FTI. OIG will now review whether the Federal marketplace performed the required verifications to determine applicants' eligibility for financial assistance payments and whether the marketplace resolved inconsistencies between self-attested information and other data sources. We are still in discussions with IRS regarding the legal authority for OIG to access FTI for the State marketplaces.

Attachment 2-Member Requests for the Record

During the hearing, Members asked you to provide additional information for the record and you indicated that you would provide that information. For your convenience, descriptions of the requested information are provided below.

The Honorable Gus Bilirakis

1. **Is HHS actually terminating coverage or withdrawing subsidies if an applicant has failed to provide documentation to address an inconsistency regarding citizenship or legal status within the 90-day period?**

   Our reports addressed the marketplaces' ability to resolve inconsistencies. Examining how the marketplaces dealt with applicants who were unable to resolve inconsistencies with citizenship and immigration status was outside of the scope of our reports and the report periods. For this reason, we do not currently have information about actual terminations of coverage or withdrawal of financial assistance.

   As a general matter, when an inconsistency in citizenship or immigration status occurs, the marketplace must first make a reasonable effort to identify and address the causes of this inconsistency by contacting the applicant to confirm the accuracy of the information on the application. If the marketplace is unable to resolve this inconsistency through reasonable efforts, the marketplace provides the applicant 90 days from the date on which the notice is received by the applicant to present satisfactory documentation to resolve the inconsistency. Generally, the date on which the notice is received means 5 days after the date on the notice. According to regulations, a marketplace may extend the inconsistency period, including inconsistencies regarding citizenship and immigration status, if an applicant demonstrates that a good-faith effort has been made to submit satisfactory documentation to resolve the inconsistency. 45 C.F.R. § 155.315(c)(3), (f)(3).

   On August 12, 2014, CMS announced that the Federal marketplace had begun to send notices to consumers with an immigration status or citizenship inconsistencies who have not responded to previous notices. CMS announced that those consumers must act now to submit supporting documents by September 5 or their marketplace coverage will end on September 30.

The Honorable Gene Green

1. **Will you please give me some examples of other programs that GAO has investigated that have inconsistencies?**

   OIG is not familiar with work by GAO that examines inconsistencies in other programs.

   OIG has not evaluated inconsistencies in other HHS programs. It is our understanding that State Medicaid programs can include a process for resolving inconsistencies with citizenship and nationality. CMS may be able to provide you with additional information about its experiences with inconsistency resolution in Medicaid.